Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Wellmark.

Coverage Period: 07/01/2021 – 06/30/2022
Coverage for: Single & Family | Plan Type: PPO

ISEBA OPTION 91 PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wellmark.com or call 1-800-381-8596. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-381-8596 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$5,000** person/**$10,000** family per calendar year. Out-of-Network: **$6,350** person/**$12,700** family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Well-child care, Tier 1 Rx, in-network preventive care, in-network independent labs, in-network prosthetic limbs and services subject to copayments are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$6,350** person/**$12,700** family per calendar year. Out-Of-Network: **$10,000** person/**$20,000** family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-381-8596 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per date of service	50% coinsurance	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners and PAs.
	Specialist visit	$100 copay per date of service	50% coinsurance	Applies to Non-PCP providers. $20 copay per date of service for in-network chiropractic services. Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	50% coinsurance	One preventive exam and one gynecological exam per calendar year. One mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your provider if the services need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	50% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. In-network independent labs for mental health/substance abuse services are not subject to coinsurance.
	Imaging (CT/PET scans, MRIs)	50% coinsurance	50% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is at www.wellmark.com/prescriptions.	Tier 1	$15 copay per prescription	Not covered	Drugs listed on Wellmark's Blue Rx Value Plus Drug List are covered. Drugs not on this Drug List are not covered. 1 copay or coinsurance for 30-day supply. 3 copays or coinsurance for 90-day supply (maintenance). Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
	Tier 2	50% coinsurance	Not covered	
	Tier 3	50% coinsurance	Not covered	
	Specialty drugs	50% coinsurance	Not covered	

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-381-8596. You can find your Coverage Manual at sbccmfinder.wellmark.com.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	50% coinsurance	------None------
	Physician/surgeon fees	50% coinsurance	50% coinsurance	------None------
If you need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance	For emergency medical conditions treated out-of-network, you may be balance billed.
	Emergency medical transportation	50% coinsurance	50% coinsurance	For covered non-emergent situations, out-of-network ambulance services are NOT reimbursed at the in-network level. The member may be balance billed for any out-of-network service.
	Urgent care	$20 copay per date of service	50% coinsurance	------None------
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	50% coinsurance	------None------
	Physician/surgeon fees	50% coinsurance	50% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $20 copay per date of service Facility: 50% coinsurance	50% coinsurance	------None------
	Inpatient services	50% coinsurance	50% coinsurance	------None------
If you are pregnant	Office visits	50% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	50% coinsurance	50% coinsurance	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	50% coinsurance	50% coinsurance	------None------

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-381-8596. You can find your Coverage Manual at sbccmfinder.wellmark.com.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	50% coinsurance	50% coinsurance	------None------
	Rehabilitation services	Office: $20 PCP/ $100 Non-PCP copay per date of service Facility: 50% coinsurance	50% coinsurance	$20 copay per date of service applies to in-network Physical and Occupational Therapists and Speech Language Pathologists.
	Habilitation services	Office: $20 PCP/ $100 Non-PCP copay per date of service Facility: 50% coinsurance	50% coinsurance	$20 copay per date of service applies to in-network Physical and Occupational Therapists and Speech Language Pathologists.
	Skilled nursing care	50% coinsurance	50% coinsurance	------None------
	Durable medical equipment	50% coinsurance	50% coinsurance	20% coinsurance applies to in-network prosthetic limbs.
	Hospice services	50% coinsurance	50% coinsurance	------None------
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	One routine vision exam per calendar year.
	Children's glasses	Not covered	Not covered	------None------
	Children's dental check-up	Not covered	Not covered	------None------

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-381-8596. You can find your Coverage Manual at sbccmfinder.wellmark.com.

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Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)	
• Acupuncture • Cosmetic surgery • Custodial care - in home or facility • Dental care - Adult • Dental check-up • Extended home skilled nursing • Glasses	• Hearing aids • Long-term care • Routine foot care • Some pharmacy drugs are not covered • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Applied Behavior Analysis therapy-covered through age 18 subject to annual limits • Bariatric surgery • Chiropractic care • Infertility treatment (excludes some services) • Most coverage provided outside the U.S.	• Private-duty nursing - short term intermittent home skilled nursing • Routine eye care - Adult (one vision exam per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-381-8596 or the Iowa Insurance Division at 515-281-5705.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About These Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$5,000
PCP copayment	$20
Hospital(facility) coinsurance	50%
Other coinsurance	50%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$100
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$6,360**

Managing Joe's type 2 Diabetes
(a years of routine in-network care of a well-controlled condition)

The plan's overall deductible	$5,000
Specialist copayment	$100
Hospital(facility) coinsurance	50%
Other coinsurance	50%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$600
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$2,570**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$5,000
Specialist copayment	$100
Hospital(facility) coinsurance	50%
Other coinsurance	50%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$2,400**

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The plan would be responsible for the other costs of these EXAMPLE covered services.

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Discrimination is against the law

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Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية, فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສ່ຽຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တ်ဒုးသ့ဉ်ညါ-နမ့်ကတိၤကညီကျိာ်,ကျိာ်တ်မၤစၤတ်ဖံးတ်မၤတဖဉ်,လၢတဘဉ်လာ်ဘူးလဲ,အိဉ်လၢနဂီၤလီၤ.ဆဲးကျိုးဆူ ၈၀၀-၅၂၄-၉၂၄၃တမ့်(TTY:၈၈၈-၇၈၁-၄၂၆၂)တက့်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

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HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajilloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Koji' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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